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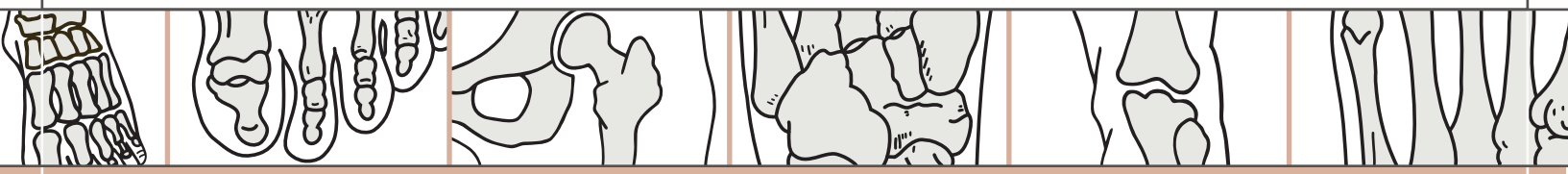
Diagnostic Radiology Coding Reference



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Thirteenth Edition

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Diagnostic Radiology

Head

PROCEDURE:

Diagnostic radiology of the head includes x-ray film imaging of structures in both the face and skull. There are two interventional procedures included in this section: myelography and dacryostography. Both involve injection of contrast into a duct followed by imaging of the duct.

CLINICAL INDICATIONS:

Head or facial trauma, injury, or pain; foreign body; sinusitis; temporomandibular joint (TMJ) syndrome; salivary gland swelling or pain; excessive tearing; mastoiditis; optic, trigeminal, or otic nerve neuroma (1st, 5th, 7th, or 8th cranial nerve tumors), etc.

CODES:

PROCEDURE DESCRIPTION	PROC CODE	RVC	WORK RVU
Myelography, posterior fossa, radiological supervision and interpretation	70010	5572	1.19
Cisternography, positive contrast, radiological supervision and interpretation	70015	5573	1.19
Radiologic examination, eye, for detection of foreign body	70030	5521	0.18
Radiologic examination, mandible; partial, less than 4 views	70100	5521	0.18
Radiologic examination, mandible; complete, minimum of 4 views	70110	5522	0.25
Radiologic examination, mastoids; less than 3 views per side	70120	5522	0.18
Radiologic examination, mastoids; complete, minimum of 3 views per side	70130	5522	0.34
Radiologic examination, internal auditory meatus; complete	70134	5524	0.34
Radiologic examination, facial bones; less than 3 views	70140	5521	0.19
Radiologic examination, facial bones; complete, minimum of 3 views	70150	5522	0.26
Radiologic examination, nasal bones, complete, minimum of 3 views	70160	5521	0.17
Dacryocystography, nasolacrimal duct, radiological supervision and interpretation	70170	5523	0.00

PROCEDURE DESCRIPTION	PROC CODE	APC	WORK RVU
Injection of contrast medium for dacryocystography	68850	N/A	0.80
Radiologic examination; optic foramina	70190	5521	0.21
Radiologic examination; orbits, complete, minimum of 4 views	70200	5522	0.28
Radiologic examination, sinuses, paranasal, less than 3 views	70210	5521	0.17
Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	70220	5521	0.22
Radiologic examination, sella turcica	70240	5521	0.19
Radiologic examination, skull; less than 4 views	70250	5522	0.18
Radiologic examination, skull; complete, minimum of 4 views	70260	5522	0.28
Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	70328	5521	0.18
Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	70330	5521	0.24
Orthopantogram (eg, panoramic x-ray)	70355	5521	0.20
Radiologic examination, salivary gland for calculus	70380	5521	0.17
Sialography, radiological supervision and interpretation	70390	5523	0.38
Injection procedure for sialography	42550	N/A	1.25
Dilation and catheterization of salivary duct, with or without injection	42660	5162	1.13

CODING INSTRUCTIONS

1. Do not code a limited study and complete study of the same area. A complete study includes as many views as necessary to complete the exam.

2. When a procedure is not described by the number of views, there is no official designation of the number of views a complete procedure includes. Therefore, it is not necessary to bill a limited procedure if less than your facility's standard number of views are acquired.

3. Code individual procedures separately when multiple anatomical areas are separately imaged. Medical necessity is needed for each separate anatomic area studied.

4. Descriptions that state a minimum number of views include at least that many views and as many more as it takes to complete the study.

5. The Medicare RVU file for physician payment contains a designator for each CPT® code to indicate if it can be reported as a bilateral procedure. The following procedures are designated as unilateral procedures that are reported twice or with a -50 modifier when performed on both sides of the body: The Medically Unlikely Edits (MUEs) assigned to each are also shown. If it is a date of service edit, the edit cannot be exceeded. This is designated as a 3 in the MAI (medically unlikely edit adjudication indicator) file from CMS. If a date-of-service edit is assigned an MUE of 1, a -50 modifier must be appended to denote a bilateral study. Some denials based on MUEs can be appealed and are noted below. Date-of-service edits with an MAI of 3 may be appealed if warranted.

   - Eye for foreign body (70030) (assigned MUE of 2—date-of-service edit)

- Mastoids (70120 and 70130) (assigned MUE of 1—date-of-service edit; may be appealed)
- Optic foramina (70190) (assigned MUE of 1—date-of-service edit)

6. The following procedures have been designated in the Medicare RVU file for physician payment as not receiving payment for two procedures when billed with a -50 or -LT and -RT modifiers:
   - Mandible (70100 and 70110) (assigned MUE of 2—date-of-service edit; may be appealed)
   - Internal auditory canals or meati (70134) (assigned MUE of 1—date-of-service edit; may be appealed)
   - Facial bones, less than three views (70140) (assigned MUE of 2—date-of-service edit; may be appealed)
   - Facial bones, complete (70150 and 70160) (assigned MUE of 1—date-of-service edit; may be appealed)
   - Dacryocystography, S&I (70170) (assigned MUE of 2—date-of-service edit)
     - » Note: Injection code (68850) should be reported with -50 modifier if injections are performed into both tear ducts (assigned MUE of 1—date-of-service edit; may be appealed).
   - Orbits (70200) (assigned MUE of 2—date-of-service edit; may be appealed)
   - Salivary gland imaging (70370) (assigned MUE of 2—date-of-service edit; may be appealed)

7. Facial bone imaging includes multiple views of the face to encompass the maxilla, zygoma, nasal bones, facial sinus walls, and orbits. If any of these included areas are also ordered for a medically necessary individual radiographic study, they can be reported separately. As NCCI edits change quarterly, closely monitor to verify that codes 70140 and 70150 are not subject to any NCCI edits with other x-ray procedures, such as mandible, orbits, and nasal bones.

8. The code for nasal bones (70160) is described as three or more views. There are no published guidelines on how to report less than three views performed. We recommend appending modifier 52 (reduced services) to code 70160 when only one or two views of the nasal bones are performed.

9. Report code 70220 when at least three views of the sinuses are performed. Use code 70210 when less than three views are performed.

10. Report code 70260 when at least four views of the skull are performed. Use code 70250 when less than four views are performed.

11. Report code 70328 when a unilateral temporomandibular examination is performed.

12. Report code 70330 when a bilateral temporomandibular examination is performed.

13. Append modifier -52 (reduced service) if both open and closed mouth procedures cannot be performed for unilateral and bilateral temporomandibular imaging.

14. Do not report either code 70328 or 70330 more than one time or with a -50 modifier. They include all views and images taken to radiographically evaluate the joint(s) and are assigned an MUE of 1 (date-of-service edit; may be appealed).

15. Report code 70355 for panoramic imaging.

16. Do not code dental x-rays separately with an orthopantogram (70355), as imaging of the teeth is included. Teeth imaging procedures are currently "0" NCCI edits with code 70355 and will not be reimbursed separately. And the pantogram is considered included in a complete bone survey (77075). If it is performed for reasons other than those for the bone survey, append a distinct procedure modifier to code 70355. Medical necessity must support this separate coding.

17. Report code 70380 for plain film imaging of a salivary gland for identification of a stone.

18. Report code 70390 for contrast imaging of the salivary duct with sialoroscopy. Report the injection procedure separately with code 42550 (without dilation of the duct) or code 42660 (with dilation of the duct). Bill each duct injected and imaged separately. All of these codes are assigned an MUE of 2, but can be appealed.

REFERENCES:

Centers for Medicare and Medicaid Services, Medically Unlikely Edits

Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File

Centers for Medicare and Medicaid Services, NCCI Edits

Clinical Examples in Radiology, Fall 09:9, Fall 11:11

CPT Assistant, May 11:10-11

National Correct Coding Initiative Policy Manual for Medicare Services

CT of the Chest (Thorax)

PROCEDURE:

CT of the chest includes imaging of the lungs and mediastinum. It does not include imaging of the heart. Images are acquired and reformatted into 2D views.

CLINICAL INDICATIONS:

Examples of associated diagnoses include infection, neoplasm, pleural fluid, cardiovascular accident, lung disease, injury, cough, shortness of breath, hemoptysis, pain, pulmonary embolism, etc.

CODES

PROCEDURE DESCRIPTION	PROC CODE	APC	WORK RVU
Computed tomography, thorax, diagnostic; without contrast material	71250	5522	1.08
Computed tomography, thorax, diagnostic; with contrast material(s)	71260	5571	1.16
Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	71270	5571	1.25
Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	71271	5522	1.08
Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	G0296	5822	0.52

CODING INSTRUCTIONS:

1. Do not report codes 71250, 71270 together on the same patient on the same day. These are "0" edits with each other. So only one procedure will be reimbursed.

   Do not report lung cancer screening exam and a diagnostic thorax CT together. These are "0" NCCI edits.

3. Evaluation for pulmonary embolus may utilize CT of the thorax or CT angiography (CTA) of the thorax depending on the technique performed. The key distinction between the two is that CTA includes evaluation of the vascular system and imaging post processing such as maximum intensity projection (MIP) or 3D reconstruction of the vascular system.

4. Use one of the CT thorax codes to report CT scan of a soft tissue mass of the upper back unless it involves the spine.

5. Report code 76380 (limited CT) or append modifier -52 (reduced study) to one of the above codes if a limited CT of the thorax is performed.

6. Do not report code 71250, 71260, or 71270 for CTA of coronary arteries. Use codes 75571-75574 for cardiac imaging applications. Also be aware of Category III CPT codes that can be

used for additional medically necessary post processing.

7. Do not code a CT chest in addition to CT of the heart (75571-75574) when performed concurrently. The NCCI bundles the chest imaging into the heart imaging. If separate and distinct imaging is performed of the chest and heart (e.g., separate encounter or separate diagnosis), append a distinct procedure modifier to the CT thorax code, with the exception of code 75571 (calcium scoring). Code 75571 bundles into the thorax code.

8. Do not report code 71250 for non-contrast imaging of the thorax during chest CTA. The non-contrast study is included in the CTA procedure.

9. Medicare covers low-dose CT (LDCT) lung cancer screening; report code 71271 for this service. Patients eligible for coverage must meet the criteria:

   - Age 55-77 years;
   - Asymptomatic;
   - Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year, 1 pack = 20 cigarettes);
   - Current smoker or one who has quit in the last 15 years; and
   - Receive a written order for lung cancer screening with LDCT. Written orders for LDCT screenings must be appropriately documented in the beneficiary's medical records and must contain the following information:
     - » Beneficiary's date of birth;
     - » Annual pack-year smoking history (number);
     - » Current smoking status and, for former smokers, the number of years since quitting smoking;
     - » Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and
     - » National Provider Identifier (NPI) of the ordering physician.

10. Before the beneficiary's first lung cancer LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that meets all of the following criteria, which must be appropriately documented in the beneficiary's medical records:

    - Must be furnished by a physician [as defined in Section 1861(r)(1) of the Social Security Act] or qualified non-physician practitioner [meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861 (aa)(5) of the Social Security Act]; and

- Must include all of the following elements:
  - » Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years, and (if a former smoker) the number of years since quitting smoking;
  - » Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - » Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities, and ability or willingness to undergo diagnosis and treatment;
  - » Counseling on the importance of maintaining cigarette smoking abstinence if former smoker or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and
  - » If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

11. See NCD 210.14 for required shared qualifications for performance of LDCT and billing instructions.
12. A follow-up CT for a patient categorized as Lung-RADS 3 or 4A on a lung cancer screening CT is reported as a diagnostic procedure (71250).

REFERENCES:

ACR Radiology Coding Source, September-October 2016

Centers for Medicare and Medicaid Services, NCCI Edits

Clinical Examples in Radiology Summer 05:4-7, Winter 17:1-4, Winter 18:3&17-19, Summer [illegible], Winter 20:7-9, Spring 20:1-4, Fall 20:9-11, Spring 21:7-10, Summer 21:15-17

CPT Assistant, Jul 07:13, Apr 10:10, Aug 11:10, Feb 21:9

CPT Changes: An Insider's View 2010, 2021

National Correct Coding Initiative Policy Manual for Medicare Services

National Coverage Determination (NCD) for Lung Cancer Screening with Low Dose Computed Tomography (LDCT) (210.14), 02/10/22

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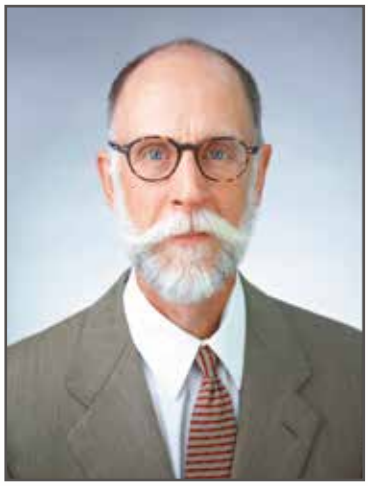

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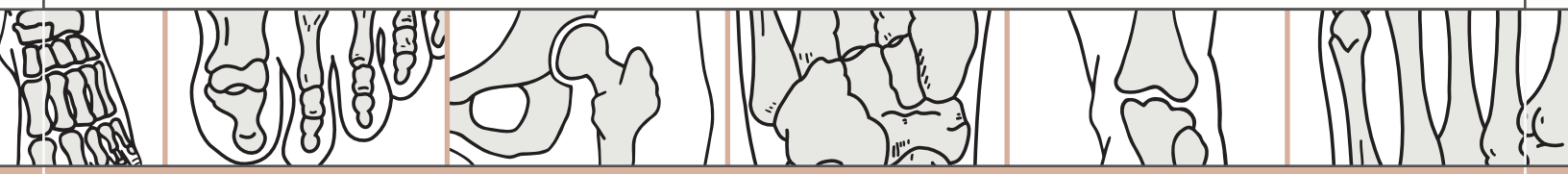

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